MONTANA LEGISLATIVE HISTORY

Chapter 357 19 95

Bill H _____ S 341 Original bill & history ✓ C

H. Committee on Joint Health Care Select			S. Committee on Public Health Welfare & Safety		
Hearing Date(s)	Mar 09	✓ C	Hearing Date(s)	Feb 18	✓ C
	Mar 16	✓ C			C
		C			C
		C			C
Date Out	Mar 17	✓ C		Feb 18	✓ C

Did this bill originate in an interim committee? ____ Yes ____ No

Committee _____ Report _____

RETURNED TO SENATE WITH AMENDMENTS
4/05 2ND READING AMENDMENTS CONCURRED 50 0
4/06 3RD READING AMENDMENTS CONCURRED 49 1
4/11 SIGNED BY PRESIDENT
4/11 SIGNED BY SPEAKER
4/11 TRANSMITTED TO GOVERNOR
4/14 SIGNED BY GOVERNOR
CHAPTER NUMBER 448
EFFECTIVE DATE: 10/01/95

SB 340 INTRODUCED BY CRIPPEN, ET AL.

PROVIDE FOR FORMATION, REGISTRATION, AND REGULATION OF LIMITED LIABILITY PARTNERSHIPS

2/09 INTRODUCED
2/09 FIRST READING
2/09 REFERRED TO JUDICIARY
2/16 HEARING
2/18 COMMITTEE REPORT—BILL PASSED AS AMENDED
2/20 2ND READING PASSED 50 0
2/21 3RD READING PASSED 50 0

TRANSMITTED TO HOUSE
2/22 FIRST READING
2/22 REFERRED TO JUDICIARY
3/06 HEARING
3/15 COMMITTEE REPORT—BILL CONCURRED AS AMENDED
3/25 2ND READING CONCURRED 89 8
3/27 3RD READING CONCURRED 91 6

RETURNED TO SENATE WITH AMENDMENTS
4/03 2ND READING AMENDMENTS CONCURRED 46 0
4/04 3RD READING AMENDMENTS CONCURRED 49 0
4/08 SIGNED BY PRESIDENT
4/08 SIGNED BY SPEAKER
4/10 TRANSMITTED TO GOVERNOR
4/14 SIGNED BY GOVERNOR
CHAPTER NUMBER 449
EFFECTIVE DATE: 10/01/95

SB 341 INTRODUCED BY HOLDEN

GENERALLY REVISE THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN

2/09 INTRODUCED
2/09 FIRST READING
2/09 REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY
2/18 HEARING
2/20 COMMITTEE REPORT—BILL PASSED AS AMENDED
2/21 2ND READING PASSED 50 0
2/22 3RD READING PASSED 50 0

TRANSMITTED TO HOUSE
2/27 FIRST READING
2/27 REFERRED TO HEALTH CARE SELECT
3/04 REREFERRED TO JOINT HEALTH CARE SELECT
3/09 HEARING
3/17 COMMITTEE REPORT—BILL CONCURRED AS AMENDED
3/24 2ND READING CONCURRED 89 7
3/25 3RD READING CONCURRED 88 9

RETURNED TO SENATE WITH AMENDMENTS
3/30 FISCAL NOTE RECEIVED
3/30 FISCAL NOTE PRINTED

3/30	2ND READING AMENDMENTS CONCURRED	50	0
3/31	3RD READING AMENDMENTS CONCURRED	49	0
4/04	SIGNED BY PRESIDENT		
4/05	SIGNED BY SPEAKER		
4/06	TRANSMITTED TO GOVERNOR		
4/11	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 357		
	EFFECTIVE DATE: 10/01/95		

SB 342 INTRODUCED BY BARTLETT

LOCATE THE LAW ENFORCEMENT ACADEMY IN HELENA, MONTANA

2/09	INTRODUCED
2/09	FIRST READING
2/09	REFERRED TO JUDICIARY
2/10	FISCAL NOTE REQUESTED
2/10	REREFERRED TO FINANCE & CLAIMS
2/15	HEARING
2/15	REREFERRED TO JOINT SUBCOMMITTEE ON LONG-RANGE PLANNING
2/16	FISCAL NOTE RECEIVED
2/16	TABLED IN COMMITTEE
2/17	FISCAL NOTE PRINTED
3/24	MISSED TRANSMITTAL DEADLINE FOR 67TH DAY
	DIED IN COMMITTEE

SB 343 INTRODUCED BY BARTLETT, ET AL.

AUTHORIZE ELECTED PUBLIC OFFICIALS TO ESTABLISH CONSTITUENT SERVICE ACCOUNTS

2/09	INTRODUCED
2/09	FIRST READING
2/09	REFERRED TO STATE ADMINISTRATION
2/10	FISCAL NOTE REQUESTED
2/14	HEARING
2/16	FISCAL NOTE RECEIVED
2/17	FISCAL NOTE PRINTED
2/18	TABLED IN COMMITTEE
2/23	MISSED TRANSMITTAL DEADLINE FOR 45TH DAY
	DIED IN COMMITTEE

SB 344 INTRODUCED BY TVEIT

DEFINE "ENERGY RECOVERY" - CLARIFY THE HAZARDOUS WASTE MANAGEMENT FEES

2/09	INTRODUCED
2/09	FIRST READING
2/09	REFERRED TO NATURAL RESOURCES
2/10	FISCAL NOTE REQUESTED
2/15	HEARING
2/15	FISCAL NOTE RECEIVED
2/15	FISCAL NOTE PRINTED
2/20	TABLED IN COMMITTEE
2/23	MISSED TRANSMITTAL DEADLINE FOR 45TH DAY
	DIED IN COMMITTEE

INTRODUCED BY Holden SENATE BILL NO. 341

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN; ESTABLISHING LIMITS ON ELIGIBILITY; PROHIBITING REFERRAL OF INDIVIDUALS TO THE PLAN FOR CERTAIN PURPOSES AND MAKING THOSE REFERRALS AN UNFAIR TRADE PRACTICE; MAKING OFFICERS AND DIRECTORS OF THE ASSOCIATION NOT INDIVIDUALLY LIABLE FOR CERTAIN ACTIONS; EXCEPTING THE ASSOCIATION PLAN FROM THE PROHIBITION AGAINST AN INSURER DENYING OR REDUCING BENEFITS FOR PERSONS ELIGIBLE TO RECEIVE PUBLIC MEDICAL ASSISTANCE; PROVIDING DEFINITIONS; DELETING PREGNANCY AS AN ASSOCIATION PLAN EXCLUSION; ALLOWING THE ASSOCIATION BOARD AND THE COMMISSIONER OF INSURANCE TO ESTABLISH REFERRAL FEES; REQUIRING WAIVER OF PREEXISTING CONDITION EXCLUSIONS UNDER CERTAIN CIRCUMSTANCES; MODIFYING THE COMPOSITION OF THE ASSOCIATION BOARD; ADDING HEALTH SERVICE CORPORATIONS TO THE MANNER IN WHICH PREMIUMS ARE CALCULATED; AND AMENDING SECTIONS 27-1-732, 33-22-113, 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1512, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Limitations on eligibility.** An individual who purchases a policy of insurance pursuant to 33-22-1516 is no longer eligible for insurance under an association plan and is subject to cancellation of enrollment if the individual:

(1) receives benefits under the Montana medicaid program as established in Title 53, chapter 6;

(2) fails to pay the premium for the policy of insurance purchased pursuant to 33-22-1516;

(3) changes residence from Montana to another state;

(4) exceeds the lifetime maximum benefit provided in the association plan; or

(5) enrolls under another disability insurance policy or plan for health service benefits. However, the individual may maintain enrollment in the association plan during a waiting period applicable to preexisting conditions under the other policy or plan. If the individual maintains the association plan during the waiting period, the association plan may coordinate the benefits with the individual's new policy or plan

and the benefits of the association plan are considered secondary to the benefits available under the individual's new policy or plan.

NEW SECTION. **Section 2. Unfair referral to plan.** An insurer, insurance producer, insurance broker, or third-party administrator may not refer an individual or an individual's dependant to the association plan or arrange for the individual or the individual's employee to apply to the association for enrollment under an association plan in order to separate the individual or the individual's dependant from coverage under a group health insurance contract, policy, or certificate obtained in connection with the individual's employment.

NEW SECTION. **Section 3. Unfair referral as unfair trade practice.** A referral made in violation of [section 2] is an unfair trade practice under this chapter.

Section 4. Section 27-1-732, MCA, is amended to read:

"**27-1-732. Immunity of nonprofit corporation officers, directors, and volunteers.** (1) ~~No~~ An officer, director, or volunteer of a nonprofit corporation is not individually liable for any action or omission made in the course and scope of ~~his~~ the officer's, director's, or volunteer's official capacity on behalf of the nonprofit corporation. This section does not apply to liability for willful or wanton misconduct. The immunity granted by this section does not apply to the liability of a nonprofit corporation.

(2) For purposes of this section, "nonprofit corporation" means:

(a) an organization exempt from taxation under section 501(c) of the Internal Revenue Code of 1954; ~~or~~

(b) a corporation or organization ~~which~~ that is eligible for or has been granted by the department of revenue ~~tax-exempt~~ tax-exempt status under the provisions of 15-31-102; or

(c) the comprehensive health association created by 33-22-1503."

Section 5. Section 33-22-113, MCA, is amended to read:

"**33-22-113. Disability insurance coverage of persons eligible for public medical assistance.** ~~No~~ (1) Except as provided in subsection (2), a disability insurance policy providing hospital, medical, or surgical expense benefits delivered or issued for delivery in this state on or after July 1, 1979, may not contain any

provision denying or reducing ~~such~~ those benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.

(2) This section does not apply to the comprehensive health association plan issued pursuant to Title 33, chapter 22, part 15."

Section 6. Section 33-22-1501, MCA, is amended to read:

"**33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; ~~and~~

(b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations~~,~~ or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk; and

(c) is not eligible for any other form of disability insurance, health service benefits, or the Montana medicaid program.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

~~(9)~~(10) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(10)~~(11) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 7. Section 33-22-1503, MCA, is amended to read:

"**33-22-1503. Comprehensive health association -- mandatory membership.** (1) There is established a nonprofit legal entity, to be known as the Montana comprehensive health association, with participating membership consisting of all insurers, insurance arrangements, societies, and health service corporations licensed or authorized to do business in this state. The association is exempt from taxation under the laws of this state, and all property owned by the association is exempt from taxation.

(2) All participating members shall maintain their membership in the association as a condition for writing health care benefits policies or contracts in this state. The association shall submit its articles, bylaws, and operating rules to the commissioner for approval.

(3) The association may:

(a) exercise the powers granted to insurers under the laws of this state;

(b) sue or be sued;

(c) enter into contracts with insurers, administrators, similar associations in other states, or other persons for the performance of administrative functions;

(d) establish administrative and accounting procedures for the operation of the association;

(e) provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association; ~~and~~

(f) provide for the administration by the association of policies that are reinsured pursuant to subsection (3)(e); and

(g) issue additional types of health insurance policies to provide optional coverage, including

medicare supplemental health insurance."

Section 8. Section 33-22-1504, MCA, is amended to read:

"**33-22-1504. Association board of directors -- organization.** (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the ~~seven~~ five participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; ~~and~~

(b) two members at large who must be participating members of the association, appointed by the commissioner; and

~~(b)~~(c) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them ~~due to~~ because of their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 9. Section 33-22-1512, MCA, is amended to read:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The premium rates of the five insurers or health service corporations used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually ~~by all insurers~~ at the request of the commissioner. The association shall ~~utilize~~ use generally acceptable actuarial principles and structurally compatible rates."

Section 10. Section 33-22-1515, MCA, is amended to read:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner ~~which~~ that facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of the association plan. The lead carrier shall pay an insurance producer's referral fee of at least $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The amount of the referral fee must be set by the board of directors of the association and is subject to the approval of the commissioner. The referral fees must be paid by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance ~~must~~ shall notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 11. Section 33-22-1516, MCA, is amended to read:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that ~~he~~ the person fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. ~~This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.~~ The association shall waive any time period applicable to a preexisting condition exclusion for the period of time that an individual was covered under the following types of coverage if the coverage was continuous to a date not more than 30 days prior to submission of an application for coverage under the association plan:

(a) an individual health insurance policy that includes coverage by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided by the association plan; or

(b) an employer-based health insurance benefit arrangement that provides benefits similar to or exceeding the benefits provided by the association plan.

~~(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan.~~"

Section 12. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7 and 33-22-113), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but ~~such~~ the maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which ~~shall~~ must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles ~~which~~ that exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes ~~which~~ that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

~~(viii) pregnancy, except complications of pregnancy;~~

~~(ix)~~(viii) routine well baby care;

~~(x)~~(ix) complications to a newborn, unless no other source of coverage is available;

~~(xi)~~(x) sterilization or reversal of sterilization;

~~(xii)~~(xi) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

~~(xiii)~~(xii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

~~(xiv)~~(xiii) artificial insemination or treatment for infertility; or

~~(xv)~~(xiv) breast augmentation or reduction."

NEW SECTION. **Section 13. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 30, chapter 14, and the provisions of Title 30, chapter 14, apply to [section 3].

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0341, reference bill, as amended

CRIPTION OF PROPOSED LEGISLATION:

ct revising the Montana comprehensive health association (MCHA) plan; establishing limits eligibility; prohibiting referral of individuals to the plan for certain purposes;

MPTIONS:

The current association plan premium is 200% of the average premium of the five insurers with the largest premium amount of individual major medical insurance in Montana. It is assumed that this premium will remain the same.

The total 1994 association plan premiums were $1,508,508. The association plan had an average of 278 participants throughout the year resulting in an average annual premium of $5,426 per participant. The increase in benefits will encourage more participation in the MCHA. It is estimated that total enrollment will grow from 278 to 407 in FY96 and that total plan premiums will increase to $2,208,382 ($5,426 x 407).

The annual assessment against members, based on comparable experience in other states with programs similar to the MCHA under the new statute and the increase in benefits, is expected to be about 50% of the total premiums received in that year. For FY96, this is estimated to be $1,104,191 ($2,208,382 x 50%).

It is assumed that 52% of the annual assessment against members will be deducted dollar-for-dollar from the premium tax. This is estimated to amount to $574,179 based upon estimated FY96 premiums. It is assumed that 43% of the premium is collected by Blue Cross and Blue Shield of Montana, which is exempt from premium tax, and 5% is attributable to other companies that owe no premium tax in any given year.

Assessments are offset against premium tax due in the year following the assessment. It is estimated that the FY97 general fund revenue will be reduced by the offset of FY96 assessments by $474,179. This is based upon the estimated FY97 assessment offset of $574,179 ($5,426 x 407 x 50% x 52%) less the $100,000 estimated assessment offset under present law ($574,179 - $100,000 = $474,179).

ISCAL IMPACT:

evenues:

	FY96 Difference	FY97 Difference
General Fund (premium tax) (01)	0	(474,179)

Dave Lewis 3-30-95

AVE LEWIS, BUDGET DIRECTOR DATE
ffice of Budget and Program Planning

Ric Holden 3-30-

RIC HOLDEN, PRIMARY SPONSOR DATE

Fiscal Note for SB0341, reference bill, as amended

SB 341

HEARING ON SB 341

Opening Statement by Sponsor:

SENATOR RIC HOLDEN, SD 1, Glendive, said SB 341 corrects several problems which have arisen in the administration of the Montana Comprehensive Health Association. This program provides health care coverage to those who are medically uninsurable. The bill allows for stabilization of board membership, elimination of cherry-picking of insurance carriers, liberalization of pre-existing conditions causes, no longer excludes pregnancy coverage, provides for optional coverage, and allows for the transfer of coverage without a break in coverage.

Proponents' Testimony:

William Jensen, Blue Cross and Blue Shield, Chairman of the Montana Comprehensive Health Association, said the proposed amendments to SB 341, which he submitted to the Committee. **EXHIBIT 7.** He said after the bill was introduced, the discovery was made that there was a problem with federal law, as the one portion of the bill which would make Medicaid always primary. This portion has been removed because Medicaid always has to be secondary to whatever insurance program there is in the state. He referred to their recent semi-annual Financial report.

He said several problems were discovered in their operation and SB 341 can cure these problems. Once someone becomes insured under the Montana Comprehensive Health Association, there is no provision to take them off the rolls when they cease to be eligible by moving from the State or obtained other insurance. This is a situation where there would be double coverage. Section 1 of the bill would allows these individuals to be taken off the rolls. There is a section dealing with immunity from liability of the directors for their actions. There is a need for Medicare supplemental insurance, particularly for people on Medicare due to disability rather than age.

He said the Insurance board is made up of seven major insurance , but revising would allow the Insurance Commissioner to appoint positions six and seven on the board.

He said the technical provision in the bill dealing with the rates. The top 5 individual coverages are averaged and the rate is set based on that, but because of the law, health service corporations, such as Blue Cross and Blue Shield, are not included in those figures. To arrive a fair rate, Blue Cross and Blue Shield's coverage need to be included, as well as other top carriers in the state.

Tom Hopgood, representing Health Insurance Associations of America, said they support SB 341.

Susan Good, representing HEAL Montana, said they are very much interested in the Montana Comprehensive Health Association and support of SB 341.

Opponents' Testimony: None

Questions From Committee Members and Responses:

SENATOR ECK asked about the pregnancy exclusion.

William Jensen said this removes pregnancy as an exemption as an exclusion under the contract.

SENATOR ESTRADA asked for an explanation of waiver requirement.

SENATOR HOLDEN deferred to **William Jensen.**

William Jensen said the law that creates MCHA, provides that a person with continuous coverage has 30 days to be reinsured and does not have to satisfy pre-existing condition requirement. An effort has been made to clarify the language and change a portion of the language in Section 11, dealing with a person taken off the rolls when they cease to be eligible.

SENATOR ESTRADA asked if this is an attempt to make switching carriers easier.

William Jensen answered in the affirmative.

Closing by Sponsor:

SENATOR HOLDEN said he received a note from Ann Ricker who supports the bill. He said, there is a segment of society who are medically uninsurable through the normal channels, but MCHA provides this channel.

EXECUTIVE ACTION ON SB 388

Motion/Vote: **SENATOR ECK moved the AMENDMENTS to SB 388 DO PASS. The motion CARRIED UNANIMOUSLY.**

Motion/Vote: **SENATOR MOHL moved SB 388 DO PASS AS AMENDED. The motion CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 381

Motion/Vote: **SENATOR ECK moved SB 381 DO PASS.**

Discussion: **SENATOR SPRAGUE** said he is confused how all of the bills in the system are going to be coordinated.

SENATOR MOHL asked about a fiscal note for SB 381 and what effect it will have on the budget before acting on this bill.

SENATOR BENEDICT said there will be no fiscal impact on the General Fund for adding a member to the Board of Nurses. The money for this additional member will come from the fees paid by nurses and will have no fiscal impact.

SENATOR BAER asked if it was self-supporting.

SENATOR BENEDICT answered, yes.

SENATOR ESTRADA asked, to whom are those with temporary licensees responsible.

SENATOR BENEDICT said they are responsible to the Board of Nursing.

SENATOR ECK said most of these individuals work for a physician, in a clinic, or county health department.

Vote: **The Do Pass motion for AMENDMENT 2 to SB 395 CARRIED UNANIMOUSLY.**

Motion/Vote: **SENATOR BURNETT moved SB 395 DO PASS AS AMENDED. The motion CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 341

Motion/Vote: **SENATOR BURNETT moved the AMENDMENTS to SB 341 DO PASS. The motion CARRIED UNANIMOUSLY.**

Motion/Vote: **SENATOR MOHL moved SB 341 DO PASS AS AMENDED. The motion CARRIED UNANIMOUSLY.**

HEARING ON SB 410

Opening Statement by Sponsor:

SENATOR JIM BURNETT, SD 12, Luther, read his written statement. **EXHIBIT 9.**

Proponents' Testimony: None

Opponents' Testimony:None

Questions From Committee Members and Responses:

SENATOR ECK asked about the funding of the inspections.

SENATOR BURNETT said, due to the USDA rule, the state program would lose the matching funds from the federal government if the state charged an inspection fee. Under the USDA, there is no

MONTANA SENATE
1995 LEGISLATURE
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

ROLL CALL DATE 2/18/95

NAME	PRESENT	ABSENT	EXCUSED
LARRY BAER	X		
SHARON ESTRADA	X		
ARNIE MOHL	X		
MIKE SPRAUGE	X		
DOROTHY ECK	X		
EVE FRANKLIN	X		
TERRY KLAMPE	X		
STEVE BENEDICT, VICE CHAIRMAN	X		
JIM BURNETT, CHAIRMAN	X		

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SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2/18/95
BILL NO. SB 341

SB - 341
Amendments
February 17, 1995

Page 1

1. Line 8
   Following "ACTIONS;"
   Strike "EXCEPTING THE ASSOCIATION PLAN FROM THE PROHIBITION AGAINST AN INSURER DENYING OR REDUCING BENEFITS FOR PERSONS ELIGIBLE TO RECEIVE PUBLIC MEDICAL ASSISTANCE;"

2. Line 15
   Following "27-1-732,"
   Strike "33-22-113,"

3. Line 23
   Following "(1)"
   Strike "receives benefits under the Montana medicaid program as established in Title 53, chapter 6:

   (2)"
   Renumber Subsections of section 1.

Page 2

4. Line 27
   Strike Section 5

Page 3

5. Line 20
   Following "insurance"
   Strike ","
   Insert: "or"

6. Line 20
   Following "benefits"
   Strike "or the Montana medicaid program"

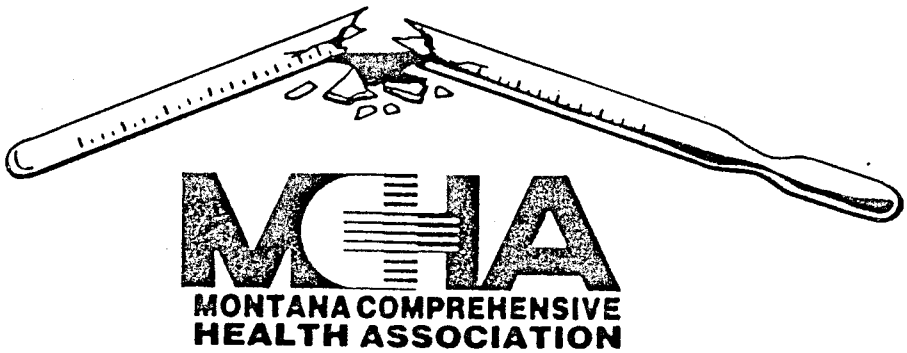
Page 7

7. Line 22

SENATE HEALTH & WELFARE
EXHIBIT NO. 8
DATE 2/18/95
BILL NO. SB 341

SEMIANNUAL REPORT OF MONTANA COMPREHENSIVE HEALTH ASSOCIATION

JULY 1, 1994 - DECEMBER 31, 1994



By: Blue Cross and Blue Shield
of Montana, Inc.

The original of this document is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

DATE 2/18/95

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 381, SB 395
SB 341, SB 388, SB 410

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Oppo
Ellie HARDY	Dale Taliaferro	SB395	x	
Stan Hall	Montana APRN Assoc.	SB395	X	
Liz Johnson	Family Planning	SB395	x	
Helen Christensen	MT State AFL-CIO	SB381	x	
Bob Ladinig	St Peters	SB388	x	
Tom Hopgood	HIAA	SB341	✓	
M Susan Good	HEAL MT	SB341	✓	
Bill Jonson	Mont Cooperative Health Assn	SB341	✓	
Nancy Elly	SRS	SB388	✓	
Frank Cote	ST Auditor	SB381	✓	
MARGARET BORTKO	APRN's	SB395	✓	
Barb Doohen	MT Nurses Assoc	SB395	✓	
Chuck Butler	Blue Cross Blue Shield of MT	SB381	✓	
Butler	Blue Cross Blue Shield of MT	SB388	✓	
David Hanson	MT Assoc. of Churches	381	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

JOINT SELECT COMMITTEE ON HEALTH CARE

Call to Order: By CHAIRMAN STEVE BENEDICT, on March 9, 1995, at 5:30 p.m.

ROLL CALL

Members Present:
Sen. Steve Benedict, Chairman (R)
Rep. Scott J. Orr, Vice Chairman (R)
Sen. Mike Foster (R)
Rep. Duane Grimes (R)
Sen. Judy H. Jacobson (D)
Sen. Ken Miller (R)
Rep. Bruce T. Simon (R)
Rep. Carolyn M. Squires (D)
Rep. Carley Tuss (D)

Members Excused: Sen. Dorothy Eck (D)

Members Absent: None

Staff Present: Susan Fox, Legislative Council
David Niss, Legislative Council
Jennifer Gaasch, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: This was a meeting where public testimony was given on HB 446, HB 531, HB 533, SB 322, SB 341, HB 85, HB 202, SB 62, SB 74, and SB 376
Executive Action: None

{Tape: 1; Side: A.}

Public Testimony:

Kate Cholewa, representing Montana Women's Lobby, said on HB 446, page 3, defined at the top of the page "A health benefit plan may not define a pre-existing condition more restrictively that these items." In (b) it talks about an ordinarily prudent person seeking medical advice. On (c) they have pregnancy existing on the effective date of the coverage of the insured person. She said they would like to see pregnancy not treated any differently than other pre-existing conditions. An ordinarily prudent women

if they trace her date of pregnancy back to a week before her policy went into effect she is an ordinarily prudent person with a pre-existing condition who would have still sought medical advice for that condition. They would like to see pregnancy not treated differently.

Tom Hopgood, representing the Health Insurance Association of America, said he would like to address HB 446 and had amendments they would like to offer to that bill. **(EXHIBIT #1)** He said the amendments were mostly technical. On line 5, page 3, they think that would be a good idea to strike that so they do not write a pre-existing condition on pregnancy. He said the bill sets a pre-existing condition for a health benefit plan, look back for 3 years, exclude it, then for a period of 12 months. It is a little better than it is for other types of disability policies which are on the market. He said he had some amendments to propose. **(EXHIBIT #2)** He said this bill said once a pre-existing condition is covered under a health insurance policy they, can transfer their health insurance policy to another company and they would not have to satisfy the pre-existing condition again. There is a provision in HB 533, Section 3, page 2, which would address the spread of premium increases. When a person becomes ill some health insurance companies have taken that person's premiums and increased them because of adverse claims experience. In Section 3, the only thing that should increase an individual's policy is an increase in his/her age. Any other reasons to increase that policy have to spread across the entire market. The company cannot take revenge on a person for getting sick. The way the bill was originally written it would apply to group policies. The thought was that group policies were already sufficiently covered under the small group act. He said the amendments would take care of that. He said they had one amendment prepared for HB 531. **(EXHIBIT #3)** He said that amendment was on page 7, line 30, and has to do with the disclosure requirements. Health care insurers and producers are to provide, at the point of application, a set of materials continuing on page 8. They think that is a lot of material. What it appears they really want is a general history of what is going on with the premiums to particular policies. They feel by the company providing a general narrative of what has gone on with the companies premiums over the past 5 years would be sufficient for that. He said they were still discussing things between the interested parties.

Claudia Clifford, representing the State Auditor's Office and the Commissioner of Insurance's Office, said was going to address HB 446, HB 533, and SB 322. The goal is to address portability. They key to understanding portability is whether or not they can even get their next policy. She that is what the issue of guaranteed issue is about. These bills deal with pre-existing conditions. She said in current law, a pre-existing condition is a problem that has occurred, there is a medical diagnosis, it is something that is documented. In one of the bills they add a definition of what pre-existing means. It would be what any

prudent person would have sought treatment for. That makes it more difficult for the consumer. It is hard for them to seek recourse if they disagree with the insurance company. It is not in the best interest. There is the look back period issue. How far back in someone's history do they look back and say this is a condition which they are either not going to cover or treat differently. In current law it is a 5-year look back period. One of the bills says they would only look back 3 years, but it then deals with rider conditions. It segregates some of the pre-existing conditions. It says that some pre-existing conditions are bad enough that they will not only apply a 12 month waiting period, but they want to note those conditions in the contract and make them wait longer on getting coverage for that. That kind of rider condition in one of the bill says that they will not cover those conditions for 4 years. The insurance company would argue that if they could not rider some conditions, especially in individual policies, they would probably choose to reject that person all together. Riders are not currently dealt with in law. Riders are not allowed because they are not dealt with and all the law says is that if a person has a past medical problem they can only have a 12 month medical problem. They need to deal with riders somehow if they are going to be allowable. If a person has a condition that has not been ridered, the bills have what is an attempt to waive the 12 month waiting period. If a person has had previous coverage and they did not have much of a lapse in coverage they do not have to go through the 12 month waiting period. That is very important for portability and as a good move in the bills. One bill says that the lapse in coverage can be only 30 days and another bill says 60 days. There is also a difference as to when that applies. They recommended they put in the 60 days and that they make it to that date of application. The day of application is controlled by the consumer. Companies vary on how quickly they can issue policies. She said if the idea was not to restrict any more on a person when they are going to their next policy then riders do not do that. Currently, if they leave the bill unamended, insurance companies can look back in someone's past history back to birth and rider any condition. They recommended that they apply the same look back period to riderred conditions as they do to the other pre-existing conditions of 3 years. They acknowledge that there is a complex issue of riders when they move to another policy. Companies have different underwriting policies. The new company may want to rider a whole new set of conditions. When they had the first policy there was only one ridered policy and when they go to the next policy there may be 4 or 5 different riders. Do they want to allow that or do they want to address that there would be no more riders in the next policy. In response to a question regarding which bill she was referring to, **Claudia Clifford** replied essentially she was talking about all three bills at one time. She said they support the concepts in all three bills of improving pre-existing conditions and improving portability. She said with the issue of riders when going to a new policy they want to allow consider that if they have a rider condition on their first policy for 4 years and they have had that policy for

2 years, when they go to the new policy do they receive the same kind of credit that they got from pre-existing conditions and they only have to fulfill 2 more years of a rider condition. She said, dealing with the retroactive applicability of a bill they believe to retroactively to allow for riders is unconstitutional under contract law. She said she had a copy of the GOP health plan in the news. **(EXHIBIT #5)** She offered amendments to SB 322 **(EXHIBIT #5)**, HB 446 **(EXHIBIT #6)**, and HB 533 **(EXHIBIT #7)**.

Larry Akey, representing the Montana Association of Life Underwriters, said they supported HB 446 and HB 533 when they were before the House Select Committee on Health Care. They support the amendments proposed by **Tom Hopgood.** He said it is true that an ordinarily prudent person does add a new standard or reintroduces a standard to the statute on pre-existing conditions. He said they did not feel that was a necessary part of the statute when the look back period was 5 years. They felt it was important to bring that standard back in if the were going to change the look back period to 3 years. They believe the rider language as it is currently contained in HB 446 as amended in the proposed amendments by **Tom Hopgood** are good and solid rider exceptions. He said there was an issue of retroactivity. That is a danger that a force to find a retroactive application of the statute unconstitutional. However retroactive applicability does solve a major problem that was in the market and will remain in the market. Riders were commonly used in insurance policies prior to a departmental interpretation about 1 ½ years ago. There are a number of policies out there today that have riders on them. They are concerned without retroactive applicability that an insurance company in the future find itself in court over that rider. They suggest a better way would be to not strike the section on retroactive applicability and the question of its constitutionality is to add a section on severability. They think that would address the issue should the courts find that they cannot retroactively apply those provisions they would not have to throw out the entire statute. They support tax deductibility of insurance premiums. They asked that they treat individual premiums, premiums written by self-employed individuals in the same way they would treat health insurance premiums in a corporation or another business. They would like to see health care treated as a deductible expense from the first dollar across the board, but that would be very expensive. It is up to this committee and this Legislature to see how much tax fairness they can afford in the area of health care. He said HB 202 was the bill that addresses insurance premiums. They would at a minimum ask that they address HB 202. SB 376 is an effort to regulate multiple employer welfare arrangements (MEWA). He said there are two reasons that insurance agents care about the regulation of multiple employer welfare arrangements. One is that they have a direct impact with the way they do health care reform in the state of Montana. The tighter things are in the regulated market, the higher they raise the limit on the number of employees in a small employer group under the small employer act. He said the more likely it will be that they will see

leakage into the self-funded market because those self-funded plans are exempted from mandated benefits and other provisions of the state insurance code. He said to the extent that they have multiple employer welfare arrangements out there that are not regulated or are very weakly regulated they are concerned that any efforts they make to provide health care reform will only end up forcing people into the unregulated market and escaping all of the things the Legislature currently is trying to accomplish. Insurance agents that market products for unregulated MEWAS may be exposing themselves financially since they are selling products for what is essentially an unauthorized insurer. Their A and O coverage probably will not cover the consequences of any financial insolvencies. It is important for the agents who are offering MEWAS that they have some sort of regulation on the books so that exposure is not there. He said that SB 376 was considered the great compromise. He said there were 2 groups that were not involved in striking that compromise. There are groups that might like to form MEWAS, but under that bill they would be prohibited. Insurance companies and insurance agents were also not involved. He asked that they give SB 376 some scrutiny. He said the supporters of SB 376 would have the people believe that they did not have to accept any form of regulation and that ERISA wipes out any efforts of the state to regulate multiple employer welfare arrangements. He said it is true that they cannot touch a single employer self-funded plan. He said ERISA says they cannot touch fully-insured MEWAS. He said they cannot regulate them except by regulating the insurance companies that provide them insurance. They cannot touch MEWAS that have been exempted by the Secretary of Labor and there are none of those in Montana. They cannot touch MEWAS that are also employee welfare benefit plans. ERISA defines what an employee welfare benefit plan. MEWAS that are not also employee welfare benefit plans can be regulated by state insurance codes. They supported SB 376 in the Senate with promise to work to strengthen it. There are three areas that the committee should look at. SB 376 sets up a dual track. It says that 4 MEWAS that currently exist. For MEWAS asking for a certificate of authority do not have to comply with demonstrating to the commissioner that they are financially solvent. New MEWAS do have to do that. SB 376 sets up a bona fide association as one of the requirements of being a MEWA. That says they can not form a new bona fide association and create a MEWA for 5 years. The bill creates certain exceptions and exemptions from the insurance laws. The compromise does provide some coverage by the insurance laws. He said on page 8, section 14, title 33, chapter 8, of SB 376, they say that they are going to comply with that except for the fact that they do not want to comply with 33-18-242. 33-18-242 is the section of the statute that gives an individual that has been injured by an insurance company an independent cause of action. They think if it is good for the insurance companies it is good for multiple employer welfare arrangements that are not also employee welfare benefit plans. They ask that they would also consider extending some of the sections of the insurance code to MEWAS. They have said in SB 376 that they are willing to subject

themselves to examinations, but not to approval of forms. It seems that they need both. They exempt themselves from contract language. One of the sections they are willing to comply with is privacy and information chapter. All of those are things the committee should look at and they would submit amendments in those areas. They think there should be some disclosure to the people who are receiving their health care through multiple employee welfare arrangements. They think a MEWA should disclose on the face of the policy or contract that it has with its insured that it is a multiple welfare arrangement that is not an insurance company and that it is not covered by all the guarantees of the statute affecting insurance companies and it is not covered by the guarantee association. He said they are issues they need to address if they are going to report out SB 376. They can either make it clear that SB 376 only applies to those MEWAS that are also employee welfare benefit plans and that all the laws of insurance in Montana affect those MEWAS that are not also employee welfare benefit plans or they can work to tighten up SB 376 in the ways he recommended.

Susan Good, representing Heal Montana, read her written testimony. **(EXHIBIT #8)**

Tanya Ask, representing BlueCross BlueShield of Montana, said they supported HB 446 and agree with the proposed amendments. They support HB 533 and agree with the proposed amendments. She said riders were important because in the individual market place is not a guaranteed issue market place. Riders allow individuals that might not get coverage to be able to get coverage for everything else accept that riderred issue. She said they supported the retroactive applicability. They feel there are problems due to the way that particular provision had been interpreted over the last year. She said she would like to comment on having portability of the riders. She said under riders, those individuals are not guaranteed issue. Even though that would allow portability in the individual market it does not say that say that an insurance company would necessarily going to take that risk. Insurance companies have different underwriting criteria. One may accept someone with a rider and anther may not accept that without a rider. She said she said the Comprehensive Health Care Authority is a pool of last resort. They have been in the process of making the benefits better under state law. She said they were trying to move those benefits up. She said that they would like to do that and they are asking to keep the potential cost in mind. They would like SB 341 that contains other provisions that the board felt changes were necessary to in order to make the operation more viable. Tax deductibility will be decided on the overall financial constraints on Montana. She said they have endorsed HB 202 dealing with strictly the deductibility of premiums for individuals. She said this was an area of concern by small businessmen who had their own individual contracts. They would like the same benefit as larger groups have. She said they would support SB 376 with the attached amendments. They would like those types of arrangements to be on

equal footing. There are already new potential to be on equal footing with those already in the self funded multi-employee welfare arrangement market place. The amendments provide basic protection such as privacy protection, newborn coverage and other things that Montana's previous legislatures have felt were important. ERISA qualifying MEWAS are precluded from some portions of state law, but not every single MEWA is.

{Tape: 1; Side: B; Approx. Counter: .1; Comments: Tanya Ask was cut off while she was talking.}

She said this legislation grants a certificate of authority. That is a license to be an insurer. When they are licensed as an insurer, consumers think it is an insurance company that is subject to all of the regulations of the state and the protection are afforded thereby. She said they were concerned with the certificate of authority. She asked that they take a look at the way it was written because they feel it may preclude some people from becoming a MEWA until the have been a bona fide association for a period of 5 years. She said there are things that people feel they cannot live with under the insurance regulation. She said one of those things was a form filing requirement. The insurance department reviews the benefit agreements that Montana consumers would receive. Another was how the contract would be laid out so that people would have an idea what the benefits under that contract would be. Another was a law that regulated how insurance companies, health service organizations, HMO's, and others conduct utilization review. She said there were very strict requirements put on there for the benefit of Montana consumers. They asked that the particular set of amendments be given careful consideration.

Tim Filz, a attorney with the Brown law firm in Billings and represents an number of MEWAS, he said he would talk about SB 376. He said a MEWA was a Multiple Employer Welfare Arrangement. Any time two or more employers get together and provide welfare benefits for their employees that is a MEWA. He said the exception to that is if the employers are related or controlled entities. He said ERISA says that state law cannot regulate employee welfare benefit plans. ERISA says that not withstanding that prohibition states can regulate insurance companies. The states can heavily regulate insurance companies even though there is an impact on a welfare benefit plan. Any employer that adopts a plan to provide health benefits for its employees is a welfare benefit plan whether that is fully insured or self funded. The state or the federal government says that Montana cannot directly regulate any employer to the extent that they provide welfare benefits to their employees. The federal government says that the state can regulate the insurance companies. The federal government says that the states can regulate multiple employer welfare arrangements to the extent that those requirements are not inconsistent with ERISA. ERISA says that under no circumstances can the state label, call, or describe a welfare benefit plan as an insurance company. That means if they have a

welfare benefits plan, it is not an insurance company and it can not be regulated as an insurance company. A single employer or certain types of multiple employer plans are also welfare benefit plans. He said the MEWA bill in defining what entities are allowed to register as MEWAS is limited to those kinds or arrangements which would qualify under ERISA as welfare benefit plans. A welfare benefit plan which would involve multiple employers is limited to arrangements that are either single industry, of if there is a bona fide employment-related bond between the employers. He said if there is that kind of relationship, then they would be a welfare benefit plan under ERISA entitled to ERISA pre-emption.

ERISA says you can regulate MEWAS if they do not violate ERISA and if they are not called insurance companies. That is the reason they allow a little bit of regulation, not a lot. He said they can be regulated if they are done consistent with the fundamental concepts and not inconsistently with ERISA. With the MEWA legislation they have defined what MEWAS are which is not currently done. They provide for a certification process. MEWAS that do not come through the process are going to be ruled unauthorized insurers. The bill provides for minimum reserves and for minimum funding. That is very crucial. It provides for reporting requirements. The act provides for penalties for MEWAS that do not comply and provides for remedies in the form of liquidation procedure for a MEWA. They agree to that regulation because it will ensure that only good, viable, healthy MEWAS exist. He said there is a dual tract because there are a number of MEWAS out there and they are not sure how many individuals are being provided benefits under existing MEWAS. They think that by coming up with some rules, such as an association must be in existence for at least 5 years prior to sponsoring a MEWA. They think that is a sound rule, but would like it to be around 2 or 3 years. They exempted existing MEWAS because if there is a MEWA that was formed 4 ½ years after the association was formed and was providing benefits to 500 individuals, are they going to say that they were going to disallow that MEWA that otherwise would meet the requirements. He said they need to say that the ones that were in existence before then can meet the requirements they will allow them to exist. They do not want to encourage the rush to form MEWAS. They are not strongly against disclosure. He said the kind of language in 33-11-1047 with respect to risk retention groups is probably an appropriate type of language to use. He said that they did agree to have all of the Fair Practices Act provisions incorporated into the MEWA bill except for the private cause of action. That is because ERISA provides a private cause of action for individuals agreed by a welfare benefit plan. He said the states can regulate MEWAS, but if it is inconsistent with ERISA. ERISA provides a comprehensive private cause of action and in having done that it is inconsistent for the state to have to create an independent private cause of action. There are things that are allowed under ERISA that are not allowed under a claim against an insurance company.

Lloyd Lockrem Jr., representing the Montana Contractors Health Care Trust, said he would like to address section 33-18-242. He said the primary function of ERISA is to protect the participant once an employer has decided to have employee benefits. He said ERISA does require full disclosure. He said "U.S. district courts have exclusive jurisdiction over civil and criminal action brought under Title 1 of ERISA. Except that cases pertaining to benefit recovery brought by participants may also be brought in state courts. U.S. district courts have jurisdiction to grant relief without respect to the amount in controversy or the citizenship of the parties. The court may decide who shall pay the court costs and legal fees. If you as a participant are successful the court may order the person you have sued to pay these costs. If you lose the court may order you to pay these costs and fees for example that finds your claim frivolous. In addition to creating rights for the plan participant, ERISA imposes duties upon the people who have the responsibility for the operation of the employee benefits plan. The people who are on the plan are called your fiduciaries of the plan and have a duty and in the interest of you and other planned participants. No one else including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA." He said they have set up a review procedure and each time they sit, they sit not as an employer, but as a trustee representing the participant. Legal action to recover lost benefits under this plan may not be brought until they have gone through the administrative procedure. They do not have to appear, but they always have that right. He submitted if and when the insurance industry provides employee benefits at affordable costs to employers in Montana who genuinely want to provide benefits, particularly health care, MEWAS will go away. He said they would commit to the committee if there was any possibility to resolution between the parties they would pledge to work towards that.

Jerry Driscoll, said he had heard a statement made that it was not known if there was any plan approved by the Secretary of Labor. Under the definition, collectively bargained, or by rural electric, or by rural telephone cooperatives are exempted from any state regulation. There are probably 29 of them so far that were approved by the United States Secretary of Labor. He said MEWAS work best when the group of employers form this and then they provide health insurance to their employees and there is portability between the employers because of the skills normally needed by those employers and the employees of anyone can transfer within that. It does not matter what the employer is, it is the skill that they want. The insurance is then portable between the employers. He said there should be some commonality of the employers.

CHAIRMAN BENEDICT replied that he understood there were some amendments that people would like to propose and they would like to have the amendments before executive action.

Lloyd Lockrem replied they would get them the amendments as soon as they could. He said he was trying to resolve an issue that has been in there.

Diane Ruff, representing Associated Employers of Montana, read from a handout. **(EXHIBIT #10)**

Gary Spaeth, the Chief Council at the State Auditor's Office, said the MEWAS they had come in contact with serve the people well. There are some that are not in Montana that have caused problems. When a MEWA goes insolvent that is where the problem occurs. He said that was what the bill was set up for. How to insure solvency. He said there is a MEWA scam business in other places. He said they were concerned if they did not have some control, it would happen in Montana. He said there are 22 cases that are the leading cases that are in a small area. He said they could either proceed to litigate a lot of issues or they could have a chilling effect. The major concern was solvency. He said the bill does what they set out to do. He said they did not want to seek to have extensive regulation for the fact that they are not in a regulatory climate. He said they looked at approval of forms and paper concerns which are important ways to regulate, but the are not equipped with staff to do that. He said this was a good starting point on regulating MEWAS. He said they do not even have a list of the MEWAS in Montana. He said the amendments **(EXHIBIT #11)** have been approved. He said they need a statement of intent because they set up a solvency standard, but if they become insolvent they did not put in the liquidation provisions of the statute and they have to adopt them by rule. The other provisions allow flexibility.

Bob Turner, representing the Department of Revenue, said he would address tax deductibility which included HB 85, HB 202, SB 62, and SB 74. He said he would like to give an idea of what is presently allowable in Montana law. **(EXHIBIT #12)** He addressed each bill and gave amendments that included an explanation of the amendments at the bottom of the page. **(EXHIBITS #13-16)**

Rick Larson, representing EBMS, said his company is Employee Benefit Management Services and they are in the business of administering employee benefit plans for single and multiple employer welfare arrangements. He said a lot of the protection comes under the Department of Labor and under ERISA. He said a lot of the things that are not covered in the bill are covered under federal law. He urged the passage of the bill with minimal amendments.

REPRESENTATIVE PEGGY ARNOTT, HD 20, said she was the sponsor of HB 533. She said in HB 533 the premium increases must be

distributed proportionably. She said insurers would not be able to selectively raise premiums on one individual with health problems. The would have to distribute the premium increases proportionally. It would make it so no one would be penalized for getting sick. She said the requirement that an individual has qualified for an insurance once they have done that and maintained coverage they do not have to go through another qualifying period. This bill is a small step forward. The 30 days was amended in committee. She said that was an acceptable length of time as amended.

Ed Grogan, representing the Montana Medical Benefit Plan and the Montana Medical Benefit Trust, said they Montana Medical Benefit Trust was a fully insured MEWA and the Montana Medial Benefit Plan provides the insurance for that MEWA. He said there are reams and reams of federal legislation and Department of Labor rules on MEWAS and before they were to make any dramatic changes, they should have a lawyer check to make sure they were not violating laws. He said the present law as in 33-22-110 says it is not a pre-existing condition unless they have seen a doctor. He said people are sick before they go see a doctor. The new rules allow for a ordinarily prudent person would determine whether or not the condition was pre-existing condition when filling out their application. The problem with waiting to see a doctor is they have had 3 claims that they have had to pay in the last year because it is only in the last year that it has applied. He said the law as it stands lets people with pre-existing conditions purchase insurance. He said previous to this year riders had allowed in Montana. They have said that riders and pre-existing condition are one in the same and they could only have a rider for 1 year. The changes are to make it so that they could not have riders. The law says 4 years and they believe that there should be no limit on the length of time for a rider. He said to put a 4 year limitation on a rider would be the same as saying that they would have to deny that person coverage. He said the new language in the bill that says a person can basically go 60 days without insurance and then sign an application should say that they be out of the market only 30 days and if they have an application within that 30 days period they would still be qualified. They support tax deductibility and any bill pertaining to that.

EXHIBIT #17 was passed out to the committee.

CHAIRMAN BENEDICT said he would open it up to anyone who wanted to address health care in general.

Tanya Ask, representing BlueCross and BlueShield of Montana, said she would like to address cost containment and early intervention and prevention. A group of people who have not been present are children who are not insured and not covered by Medicare or Medicaid. The Caring Program for Children sponsored by the Caring Foundation of Montana. This program is a private effort that is a cooperative effort on the part of physicians,

hospitals, insurance agents, physician assistants, nurse practitioners and the whole health care community as well as individuals and groups around the state. She said the program was a non-profit program which was started 1 ½ years ago. She said the idea was that frequently children do not receive primary preventive health care benefits when their parents are in transition. The program provides benefits for well child visits, regular office visits, x-ray lab services, and out-patient surgery. It is not designed to be 100% coverage, but it is designed to take care of most of the services that most children need. The cooperation of health care providers is important because those who participate in the program receive a lower level of reimbursement to cover the children. They know that they are going to be paid for taking care of that child, they will not have to worry about deductibles or co-payments, and that takes care of an administrative burden. This program has provided benefits for over 600 children in Montana. The reason they are bringing the program to the committee is to notify them that the more dollars that come in the more they have to help the children. They are bringing the idea of a public private initiative. The idea would be to have a match and that there are so many public dollars before private dollars are put in.

Jeffrey H. Strickler, M.D., read his written testimony. **(EXHIBIT #18)**

{Tape: 2; Side: A.}

CHAIRMAN BENEDICT said that there was not a vehicle for this issue in the legislature. The wisdom of the people that chose the bills that came into this committee were such to take the bills that were alive in the process. He said that these presentations could best be made to the appropriations committee if **SENATOR DOROTHY ECK'S** bill made it to that process. He thanked them for making those concerns.

<u>Questions from the Committee:</u>

None

MONTANA SENATE
1995 LEGISLATURE
JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL DATE 3-9-95

NAME	PRESENT	ABSENT	EXCUSED
SENATOR DOROTHY ECK			X
SENATOR MIKE FOSTER	X		
REPRESENTATIVE DUANE GRIMES	X		
SENATOR JUDY JACOBSON	X		
SENATOR KEN MILLER	X		
REPRESENTATIVE BRUCE SIMON	X		
REPRESENTATIVE CAROLYN SQUIRES	X		
REPRESENTATIVE CARLEY TUSS	X		
REPRESENTATIVE SCOTT ORR, VICE CHAIRMAN	X		
SENATOR STEVE BENEDICT, CHAIRMAN	X		

The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 380

Motion/Vote:

REP. SIMON MOVED TO TABLE SB 380. The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 341

Discussion:

Rick Hill discussed the amendments **(EXHIBIT #2).**

SEN. FOSTER said the last amendment would strike "sterilization or", he asked why that was a proposed amendment.

Rick Hill said that was on the excluded list and is now on the included list.

Motion/Vote:

REP. SIMON MOVED the amendments to SB 341. **(EXHIBIT #1)** The **MOTION CARRIED UNANIMOUSLY.**

Motion:

REP. SIMON MOVED SB 341 **DO PASS AS AMENDED.**

Discussion:

REP. GRIMES said they have limited the cost to 200%, they have expanded the benefits, would the association members pay an increased prorated amount in the association to cover increased benefits and the decreased 200% level.

Rick Hill said it would increase the premium by about $25 per month.

REP. GRIMES asked what would it do to the prorated assessment for the members.

Rick Hill referred the question to **Tanya Ask.**

Tanya Ask, representing Blue Cross and Blue Shield of Montana, said currently the premium level for the Comprehensive Health Care Association is at 200%. It is contemplated that it would remain at 200%. The assessment level has been relatively low over the last 1 ½ years so it was not contemplated that it would increase significantly with an increase in premiums.

CHAIRMAN BENEDICT said they have not gone up to the 400% cap and they have gone up to about 200% so they were going to put the cap at 200% so that the assessment could rise sometime in the future if the pressure was there.

REP. SIMON said the assessment was against all carriers of disability insurance and any assessment made against those carriers was allowed as a deduction against their premium tax.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

REP. TUSS would carry the bill on the House floor.

EXECUTIVE ACTION ON HB 466

Motion:

REP. ORR MOVED the amendments **(EXHIBIT #3 & #4)**

Discussion:

Rick Hill read and explained **(EXHIBIT #3 & #4).**

CHAIRMAN BENEDICT said there was some insertive language on page 4, #32, and the line that started with "section expenses include administrative expense, and one half the program net loss for the previous calendar year." He asked if he could explain that.

Rick Hill said the language they currently had did not provide a mechanism for recovery if the reinsurance was underestimated for the year. That would allow that any loss from the previous year could be added to the expenses and anticipate a loss in the calculation of the assessment for the next year.

CHAIRMAN BENEDICT said they would use that as a conceptual amendment because it was needed in the bill.

SEN. ECK asked if everyone was in agreement with the amendments.

Rick Hill said that everyone was in agreement with everything they have discussed so far.

REP. SIMON asked if "upon year end" of amendment #31, should be two words and not one.

Susan Fox replied that was the way it was in the bill and they were striking it so they have to show the way it was in the bill.
Vote:

The **MOTION CARRIED UNANIMOUSLY.**

MONTANA SENATE
1995 LEGISLATURE
JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL DATE 3-16-95

NAME	PRESENT	ABSENT	EXCUSED
SENATOR DOROTHY ECK	X		
SENATOR MIKE FOSTER	X		
REPRESENTATIVE DUANE GRIMES	X		
SENATOR JUDY JACOBSON	X		
SENATOR KEN MILLER	X		
REPRESENTATIVE BRUCE SIMON	X		
REPRESENTATIVE CAROLYN SQUIRES	X		
REPRESENTATIVE CARLEY TUSS	X		
REPRESENTATIVE SCOTT ORR, VICE CHAIRMAN	X		
SENATOR STEVE BENEDICT, CHAIRMAN	X		

HOUSE STANDING COMMITTEE REPORT

March 17, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **Senate Bill 341** (third reading copy -- blue) **be concurred in as amended.**

Signed: _____

Steve Benedict, Chair

Carried by: Rep. Tuss

And, that such amendments read:

1. Title, line 11.
Following: "EXCLUSION;"
Insert: "REVISING ASSOCIATION PLAN MINIMUM BENEFITS;"

2. Page 5, line 24.
Strike: "be less than 150% or more than 400%"
Insert: "exceed 200%"

3. Page 7, line 24.
Following: "(1)"
Insert: "(a)"

4. Page 7, line 25.
Strike: "80%"
Insert: "50%"

5. Page 7.
Following: line 28
Insert: "(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of $500,000."

Committee Vote:
Yes 10, No 0.

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6. Page 7, line 29.
Following: "following"
Insert: "medically necessary"

7. Page 7, line 30.
Strike: "provided for in for 33-22-111"
Insert: "and when designated in the contract"

8. Page 8, line 13.
Following: "purchase of"
Insert: "durable"

9. Page 8, line 15.
Strike: "and"

10. Page 8, line 16.
Strike: "."
Insert: ";

(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual maximum of $1,000;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

(o) pregnancy, including complications of pregnancy;

(p) newborn infant coverage, as required by 33-22-301;

(q) sterilization;

(r) immunizations;

(s) outpatient rehabilitation therapy;

(t) foot care for diabetics;

(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and

(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved in advance by the insurer."

11. Page 8, lines 18 and 19.
Strike: subsection (i) and (ii) in their entirety

Renumber: subsequent sections

12. Page 9, line 7.

Following: "condition"
Insert: ", except as provided by subsection (2)"

13. Page 9, line 13.
Strike: subsection (vi) in its entirely

Renumber: subsequent subsections

14. Page 9, line 18.
Strike: "sterilization or"

-END-

3-16-95

Insurance Reform Testimony
Rick Hill exhibit one
March 16, 1995

The issues surrounding small group reform and the Small Employer Health Insurance Availability Act go beyond one bill. The amendments I will present and explain deal with five bills:

- HB446 – preexisting conditions
- HB466 – small group insurance reform revisions
- HB531 – general reform proposal
- HB533 – general health plan revision and individual insurance market reforms
- SB341 – Montana Comprehensive Health Association revisions

The amendments address five general areas within small group and general health insurance market reforms:

1. Benefit design
2. Reinsurance program
3. Conversion coverage
4. Disclosure/Comparison information
5. Montana Comprehensive Health Association

The issues were addressed with the intent of providing more affordable health care benefit options in the individual and group markets.

The amendments strengthen the Small Group Availability Act to address concerns that the cost of guaranteed issue is being borne solely by the small group market. They allow comparison of one uniform product from insurer to insurer. They provide a guaranteed price for a leaner benefit conversion plan, providing comparable disclosure information from one insurer to another when a consumer is shopping for health insurance, and they enhance the benefits for folks who are served by the Montana Comprehensive Health Association.

I will deal with amendments one bill at a time, but first I need to explain the health benefit plans which run throughout several of these bills. We started with the current Montana Comprehensive Health Association benefit plan, and separated it into two parts, actual benefits and financial criteria or insured financial responsibility, which means deductibles, copayment levels, lifetime maximums and the like.

<u>Benefit Plan Explanation</u>

An outline of all the benefit plans is attached to the testimony for your information.

Uniform Benefit Plan – The Uniform Benefit Plan must be made available to all individuals and all groups (of 3-25 employees) by health insurers and HMOs. This plan will be non-guaranteed issue, and is designed as a low cost catastrophic benefit plan for individuals, and for small groups who want to be subject to underwriting standards.

1. Enhance current MCHA benefits by adding coverage for listed transplants and several other services.

2. Give the board flexibility to provide more than one level of benefits, so long as it continues to offer the current $1,000 deductible, 80/20 plan with an expanded lifetime maximum of $500,000.

I can tell you from first-hand experience that this has been a grueling, time-consuming, high intensity level process by which we have reached consensus on each of these issues.

Each party has had to give considerable ground from their original positions on any number of issues.

I believe the people of Montana have been well served by the process. We have made substantial improvements in the small group insurance market as well as expanding reforms in the individual market and insurance industry as a whole.

Now that we have dealt significantly with insurance issues, I hope when you return in 1997 we can focus as much time and energy on cost issues which will continue to be at the forefront of health care and our ability to purchase insurance and health care services.

2. Clarification is made for disability income insurance to allow for conditions manifesting themselves during the first twelve months of coverage.

3. Clarifies the use of elimination riders, a mechanism whereby insurers can cover a person with a specific health condition which normally would preclude that person from getting insurance. The insurer riders out that condition, and accepts the individual for all other health conditions or incidental injuries. This has been standard practice in the marketplace, but only recently the Insurance Department said the practice was not allowed. Therefore, this amendment clarifies what has been standard practice.

4. Retroactive applicability -- important because riders have not previously been specifically addressed in Montana law, but have been an industry practice not precluded by Montana law for a number of years.

House Bill 531 -- Medisaves, Basic Plan Design, information, etc.

The amendments to this bill remove all sections but the information reporting requirements on health care facilities and providers. All other provisions are addressed in other bills, with the exception of Section 6 -- standardized claim form. That provision has been addressed for insurers through administrative rule by the Insurance Commissioner. The Health Care Advisory which is being created by HB511 should continue to pursue this for other payors, where it has jurisdiction.

House Bill 533 -- health benefit plan revision, preexisting waiver portability

1. In addition to the individual market reforms contained in this bill, insurers and HMOs will now be required to meet certain insurance product disclosure standards for prospective applicants. These standards will allow comparison of benefits, financial requirements like deductibles, potential price and underwriting characteristics, and general premium trend information. (Amendment 3, New Sections 5-7)

2. The Uniform Benefit Plan which all insurers will be required to make available to individuals and groups on an underwritten basis is defined in Amendment 3, New Sections 8-10.

3. Conversion -- for the past 14 years, individuals who leave a group insurance plan have had the right to convert to individual coverage on a guaranteed issue basis without preexisting condition applicability. The conversion right has now been expanded to include conversion to the lowest cost Basic Plan at 150% of the highest rate for that plan.

Senate Bill 341 -- Montana Comprehensive Health Association

The MCHA board had recommended some statutory changes to the current benefit plan, and has also expanded benefits where they have been able to do so. The amendments:

Exhibit #2
3-16-95

Amendments to Senate Bill No. 341
Third Reading Copy

Requested by Sen. Benedict
For the Joint Select Committee on Health Care

Prepared by David S. Niss
March 16, 1995

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8. Page 8, line 13.
Following: "purchase of"
Insert: "durable"

9. Page 8, line 15.
Strike: "and"

10. Page 8, line 16.
Strike: "."
Insert: ";
(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of

the expense, up to an annual maximum of $1,000;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

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